Premier
Cancer Care and Infusion Center

MEDICAL RECORDS RELEASE

Patient Name _____ Date of Birth _____

I hereby authorize,

Name of disclosing party _____ Phone Number _____

Address _____

City, Sate & Zip _____

☐ Entire Medical Record
☐ Information limited to the following: _____

_____

Release Information To
Premier Cancer Care and Infusion Center
7065 N. Maple Ave Suite 102
Fresno, CA 93720
Phone 559-554-2100
Fax: 559-554-2114

DURATION: This authorization shall become effective immediately and shall remain in effect for 30 business days.

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the requestor may not lawfully use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship of Representative